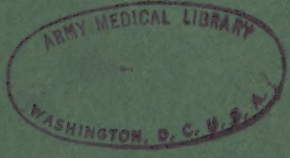
The EDUCABLE MENTALLY HANDICAPPED CHILD *in Illinois*

(Second Edition)



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STATE OF ILLINOIS

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COMMISSION FOR HANDICAPPED CHILDREN

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FOREWORD

The second edition of this study is issued by the Illinois Commission for Handicapped Children, in response to numerous requests, in order to make available an up-to-date report on what is being done and what yet needs to be done to enable the mentally handicapped child to make an optimum adjustment to society.

Since the first edition was published in 1943, considerable progress has been made in the Illinois program for children who are mentally handicapped but educable. While the gains made thus far are encouraging, they are but a beginning and represent perhaps the simpler part of the task.

The major part of that task still lies before us in the provision, in local communities, of services which State legislation has made possible but has not created. The development of these services now depends upon local initiative.

Acknowledgement was made, in the first edition, of the work of Miss Eveline Blumenthal and Mr. Warren Kingsbury and of the advice of Mr. Edward Stullken. The revisions incorporated in this edition are the work of Miss Jane Bull, Informational Representative, Miss Daisy Byler, Research Analyst, and Miss Dorothy L. Cornwell, Medical Assistance Consultant, of the staff of the Illinois Commission for Handicapped Children. Grateful acknowledgement is hereby made to them for their fine services.

MRS. HARRY M. MULBERRY,
Chairman.

Definition of the Problem

For many years the problem of mental deficiency was associated almost wholly with pauperism, immorality, alcoholism, delinquency, and criminality. It was not until the introduction and extensive application of more accurate mental tests and the refinement of interpretive techniques that it was recognized that there is another large group of mentally deficient—those formerly judged to be indifferent, lazy, or lacking in will power, but who are instead inherently limited in mental endowment and incapable of meeting all of the demands which society makes of them. As children, those in this group benefit but little by the traditional formalized education. Yet these mentally handicapped children are educable in the sense that the large majority can, with special training and education, be enabled to live happily and participate successfully in community life.

Defining what is meant by the educable mentally handicapped child is difficult, since diagnosis of mental deficiency has implications in many fields—psychology, education, medicine, neuro-pathology, biology, genetics, psychiatry, and the social sciences. Thus, a satisfactory definition for one field would not always meet the needs of others. Although classification on the basis of intelligence level offers a convenient starting point, it must be recognized that any boundaries which are established should remain flexible to permit the inclusion or exclusion of those whose intelligence scores would be affected by extenuating circumstances of physical, psychological, or social nature.[1] A relatively simple rural situation, for instance, makes much less demand upon the adaptability of a person than does a highly complex urban environment. Thus, while mental deficiency might not prevent a happy and adequate adjustment in the former case, it would be a serious handicap in the latter. It is this variation of social competence with the situation that justifies opposition to classification of mental defectives in hard-and-fast groups.

With this in mind, the following definition of the educable mentally handicapped child is offered:

An educable mentally handicapped child is any child whose rate of mental development, as measured by individual psychological ex-

[1] Intelligence measurements are generally stated in terms of the I.Q., or intelligence quotient, representing the relationship between the mental age and chronological age. An I.Q. of 100 is the mid-point of the normal group measuring from 90-110; 80-90 is dull normal; 70-80, borderline; and 50-70, feebleminded. The idiot and imbecile, low-grade mental defectives, are not considered educable in terms of independent community life.

amination, has been retarded from birth or early age, but who requires and "may be expected to benefit from special educational facilities designed to make him economically useful and socially adjusted."[1]

Social and Economic Implications

The social and economic implications of mental deficiency affect the entire structure of our national life, sometimes in ways that are obvious and measurable, but more frequently in long-range effects which cannot be detected and isolated in causal relationship to mental defect.

The increase in industrialization and urbanization of social life, while not increasing the number of the mentally deficient, has decreased the number of situations in which they can make satisfactory adjustments. As we become more industrialized and urbanized it becomes increasingly difficult for the unskilled group which contains most of the mental defectives to find employment. It should be noted in this connection that this group is reproducing itself two to three times faster than the professional population,[2] and that the proportion of feeble-minded among dependent families is much in excess of that found in the general population.[3] Thus, the marginal and substandard living conditions characterizing a large majority of the mentally deficient tend to be perpetuated.

The emotional solidarity of the family may also be disrupted by the conflicts created by the presence of a retarded child in the home. After making due allowance for possible inherited tendencies, a child's behavior patterns and personality makeup are the result of his association with others. In the case of the mentally deficient child, all such associations, whether in home, school, or community, are highly colored by the degree of his acceptance. In the home, mentally deficient children are often rejected; frequently their mental defect is willfully ignored or unaccepted, and the children are faced with the emotional hazards of enforced competition with those

[1] The last phrase of the definition has been taken from An Act authorizing school boards to establish and maintain special educational facilities for educable mentally handicapped children. *Ill. Rev. Stat. 1945;* Chap. 122, § 12-20, 3.

[2] *See* Warren S. Thompson, "Some Factors Influencing the Ratios of Children to Women in American Cities, 1930," *Amer. J. Sociology,* 45 (September, 1939), 183-99; Lorimer and Osborn, *Dynamics of Population* (New York; Macmillan Co., 1934); and Frank W. Notestein, "The Differential Rate of Increase Among the Social Classes of the American Population," *J. Social Forces,* 12 (October, 1933), 21.

[3] *White House Conference on Child Health and Protection, Section IV, The Handicapped; Prevention, Maintenance, Protection,* (New York: Century Co., 1933), p. 344.

of superior endowment. In school, these children experience repeated failures, lose self-confidence, become habituated to failure, and frequently suffer further rejection from teachers who are resentful because of the trouble caused by their inefficient academic work and the reflection their failures bring upon the teacher's record. Extending the age of compulsory school attendance has accentuated this problem. Constant frustration through failure to meet social demands frequently leads to emotional instability, development of defense mechanisms, and negativistic attitudes, in rebellion against situations beyond the child's control. In mentally deficient adolescents, the problem is made more acute by the fact that they differ physically, socially, and emotionally from the younger pupils with whom they are grouped because of their mental level.

A special personality difficulty is presented by the mentally handicapped delinquent. Because the mentally deficient cannot conform to group standards of attainment, they tend to develop overreaction in the form of submissiveness or aggressiveness to compensate for this failure. Such over-compliance or over-defiance may lead to delinquency. The problem of the defective delinquent is of major concern since the educational therapy planned for the non-delinquent defective is not adapted to the needs of this group.

That mental retardation proved a serious handicap in the armed forces is evidenced by the fact that up to April, 1942, 12.55 out of every 1,000 Illinois selectees were rejected as unfit for military service for reasons of mental deficiency.[1]

The mentally deficient child who also is crippled, blind, or defective in speech or hearing presents a doubly serious problem. Speech and hearing defects rank high among the physical stigmata associated with mental deficiency. In one study, only 37 per cent of the mental defectives possessed normal speech.[2] In another, it was noted that the incidence of defective hearing increased to a certain extent with decreased intelligence level.[3] Sensory defects are easily confused with mental defect and complicate the problem of accurate diagnosis. The blind, the mute, and the hard-of-hearing are so deprived of the social and sensory stimuli which provide food for mental growth that they are frequently classified as feeble-minded and, indeed, occasionally are so retarded as a result of their handicap that they require

[1] Data secured from Lt. Col. E. Mann Hartlett, State Medical Officer for the Selective Service System in Illinois, May 7, 1943.

[2] Jacob Sirkin and William Lyons, "A Study of Speech Defects in Mental Deficiency," *Amer. J. Ment. Deficiency*, 46 (July, 1941), 77-80.

[3] Grover A. Kempf and Selwyn D. Collins, *A Study of the Relation between Mental and Physical Status of Children in Two Counties of Illinois*, Reprint No. 1301 from *Public Health Reports*, U. S. Public Health Service, Vol. 44, No. 29, (Washington: Gov't Printing Office, 1929), pp. 1743-84.

special educational facilities such as are planned for the mentally deficient. Certainly, such children deserve special consideration.

Extent of the Problem

Studies outside of Illinois Estimates of the extent of the problem of mental deficiency are many and varied. They present little that is comparable, since the types of tests on which they are based, the conditions under which they are administered, and the differences in methods used all tend to result in widely varying estimates. These differences, plus the lack of any universally accepted definition of mental deficiency, make accurate estimates difficult. As Doll states:

> **The precise amount or kind of intelligence required for self-sufficiency has never been determined. There is a futile tendency to fix these intellectual limits for social adequacy at a definite limen such as I.Q. 70, or mental age 10. As a matter of fact, social success being contingent on many factors in addition to intelligence, the intellectual limits for social adequacy are represented in a border zone rather than a borderline. Use of the Stanford-Binet measures alone is of doubtful value for disingushing the socially inadequate of borderline intelligence from the socially adequate.[1]**

Personality, emotional, and situational factors play so important a part in an individual's social competence that no sharp line can be drawn between the mentally deficient and the so-called "normal" group. This should be kept in mind in considering the following estimates of the extent of mental deficiency.

Of major importance in calling attention to the problem of mental handicap throughout the United States was the report of the Committee on Mental Deficiency to the White House Conference on Child Health and Protection, held in 1930. "Mental deficiency" was defined to include not only the lower grades of feeble-mindedness but also those of borderline intelligence, and the intellectually subnormal (commonly termed morons). The committee concluded that 1 per cent of the total population is definitely feeble-minded and that another 14 per cent are to some degree mentally deficient, that is, possessed of an intelligence below a mental age of twelve years.[2] It

[1] Edgar A. Doll, "Criteria of Mental Deficiency," *Psych. Exchange,* III, No. 6 (1935).

[2] The White House Conference report states: "This level is variously stated in terms of intelligence quotient, I.Q.; scales based upon an upper development limit of sixteen years state it as 75 I.Q.; those having an upper limit of fourteen years state it as 85 plus I.Q. In either case, the mental age, twelve years, is identical. At present some states use the fourteen year upper limit, but many states, for example, Massachusetts, use the sixteen year upper limit. I.Q.'s throughout this report are on a fourteen year basis. . . .; the 60 to 85 I.Q. limits to which reference is most frequently made are *approximately* 50 to 75 I.Q. on the sixteen year basis, all Stanford-Binet." White House Conference, *op. cit.,* p. 331.

is with this latter group that this study is concerned. On the basis of the 1940 Federal census, this group would include approximately 18,500,000 persons. Since 36.3 per cent are under twenty-one years of age, there would be 6,715,000 children so handicapped in the United States. Many of these are more or less adequately meeting the demands placed upon them in community life. It is estimated, however, that 35 per cent, or 2,350,000 are socially maladjusted as well as mentally subnormal.

A second source which can be used as a basis for national estimates is the report on special education issued by the Office of Education of the Federal Security Agency. Special education is usually found only in cities; therefore, this estimate is from an urban point of view. In 1940 the Biennial Survey of Education reported the number of mentally deficient in special schools and classes in city school systems to be 98,416, less than one-fifth of the estimated 500,000 mentally retarded children in the United States who are in need of special educational adjustment.[1] According to Elise Martens, Senior Specialist in the Office of Education, incapacity for academic achievement to some extent characterizes about 25 per cent of elementary school children, while 5 per cent have an I.Q. of 78 or less.[2]

Studies in Illinois There has been no systematic effort to determine the number of mentally handicapped children in Illinois. Estimates as to the extent of the problem in this state must therefore be arrived at by applying the percentages presented for the United States as a whole, checking these against the information obtained by the limited surveys which have been made within the state.

The Federal census of 1940 listed 2,515,657 children under twenty-one in Illinois, or 31.9 per cent of the total population of the state. If 14 per cent of these may be classified as intellectually subnormal but not of low-grade mental deficiency, there are approximatey 350,000 children so handicapped in Illinois. If we omit the preschool age group, there remain 275,000 children between the ages of 5 and 21 who are in need of special education and training. If, as suggested by the White House Conference Report, some 35 per cent of these are socially maladjusted as well as intellectually subnormal, then there are approximately 100,000 children of school age in Illinois who are particularly in need of such services to enable them to meet more satisfactorily the demands of community life.

[1] Elise H. Martens and Emery M. Foster, *Statistics of Special Schools and Classes for Exceptional Children*, U. S. Office of Education, Federal Security Agency (Washington: Gov't Printing Office, 1942), pp. 6, 7.

[2] Elise H. Martens, *A Guide to Curriculum Adjustment for Mentally Retared Children*, Bull. 1936, U. S. Office of Education (Washington: Gov't Printing Office, 1936), p. 8.

Three limited surveys have been made within the state which lend themselves to interpretation in drawing a picture of the extent of the problem in the state as a whole. The most extensive effort in this direction was the survey made in 1940 under the direction of the Superintendent of Public Instruction. A questionnaire was sent to 182 school districts (116 elementary, 23 high school, and 43 unit school districts) representing a total enrollment of 250,270 school children. No intelligence tests were requested, and the results were highly subjective in that they represented only the opinion of the school district officials as to the mental capacity of the children reported. For purposes of this survey, a handicapped child was considered to be "any child for whom suitable education and training involves an expenditure of money in excess of educating less seriously handicapped children."[1] The number of mentally retarded children reported from all districts was 5,092, or 2.0 per cent of the total enrollment, and 21.4 per cent of all the handicapped. Applying this percentage to the total number of children reported in the 1940 Federal census as enrolled in school in Illinois would yield an estimate of approximately 40,000. This estimate can be taken as representing the minimum extent of the problem in Illinois.

More limited in numbers studied, but more carefully and accurately carried out was the joint investigation made by the United States Public Health Service and the Illinois State Department of Public Welfare in 1928. Approximately 5,000 elementary school children were given physical and mental examinations in two widely separated counties in Illinois. Group mental tests were administered to all the children, followed by individual tests for those making low scores on the group test. All psychological examinations were given by the Institute for Juvenile Research. The results of the mental tests indicated that 11.7 per cent of the white children were mentally retarded, having I.Q.'s below 80.[2] Applied to the total school population of Illinois, this would yield an estimate of 230,295 mentally handicapped children between the ages of five and twenty-one. If, as seems probable, 35 per cent are socially incompetent as well as mentally deficient, there are more than 80,000 children so handicapped. It must be noted that the intellectually subnormal group with I.Q.'s between 80 and 90 are not included. The estimate would be considerably higher if they were.

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[1] "Summary of Reports Received by the Illinois Superintendent of Public Instruction in Regard to Handicapped Children in Illinois," unpublished report dated September, 1941.

[2] Kempf and Collins, *op. cit.*, p. 7.

A third study in Illinois was the survey of Chicago Public Schools conducted in 1932 under the direction of Dr. George D. Strayer, Institute of Educational Research, Teachers College of Columbia University. The Strayer survey indicated that 4.7 per cent of school-age children were mentally retarded.[1] Applied to the 1940 Federal census of Illinois, this would mean that some 90,000 children in Illinois are so handicapped.

Summary and evaluation In summary, although surveys of the extent of mental deficiency vary greatly because of differing definitions of type and degree, the midpoint between the lowest and highest estimates indicates that there are at least 70,000 children of school age in Illinois in need of an educational program especially planned for the mentally handicapped.

A State Program for Educable Mentally Handicapped Children

The development of a state program for educable mentally handicapped children requires careful consideration. It should take full advantage of the experience which such states as Pennsylvania, Wisconsin, New York, Massachusetts, New Jersey, and Minnesota have had in attacking this problem. It should include:

1) Adequate facilities for early recognition and diagnosis.
2) Provision for opportunities for education and training, both through state schools and special classes in the regular schools.
3) Adequate institutional facilities, including colony care.
4) Extra-institutional supervision of all mentally deficient children who cannot be admitted to institutions or for whom institutional care is undesirable, including guidance and assistance to parents of those children who are cared for in their own homes.
5) Vocational guidance, training, and placement.
6) Planned teacher-training.
7) Continuing research to determine more adequately the nature of the problem of mental deficiency and the needs, capacities, and welfare of the mentally deficient child.

[1] George D. Strayer, *Report of the Survey of the Schools of Chicago* (New York: Columbia University Press, 1932), II, 94.

Identification and diagnosis A state-wide program of case-finding is of first importance, not only to determine the extent of the problem so that an adequate program may be planned and organized, but also to make available to the handicapped child proper educational and training facilities at an early age when they will be most beneficial. Early recognition and treatment help to prevent development of personality disorders and undesirable behavior patterns, and afford a maximum amount of time to foster development of desirable traits, habits, and attitudes. In addition, much costly waste of time and effort in attempts to educate the child in the standard school program is eliminated.

Compulsory education laws assure a contact with all children at the age of six or seven. At that time of first entrance into school, a careful social, medical, educational, psychiatric, and psychological study should be made of each child who presents a special problem. Competent staffs should be provided to conduct such examinations on a state-wide basis. This step will prevent confusing mentally deficient children with those who are psychotic, who present behavior difficulties, or whose retardation is caused by sensory defects or other physical disorders.

In every community having a school population of 5,000 or more, there should be a permanent full-time child guidance clinic staffed by a psychitarist, a psychologist, and the necessary social workers. For thinly populated and rural areas, the traveling clinic is a solution to the problem. This should operate full-time, making every possible use of existing facilities and local resources such as state schools, hospitals, teachers colleges and universities. The traveling clinic plan has been eminently successful in Massachusetts, where a staff made up of a psychiatrist, a psychologist, and in some instances a social worker, operates from each of fourteen state mental institutions. Every city and town is covered periodically. Over 9,200 children were examined in 1940, at a cost of $5.19 for each examination.[1] Each case was studied with respect to physical condition, family history, personality adjustment, developmental history, school progress, and mental status.

Provision for such diagnostic services should be accompanied by a state-wide registration and continuing census of all mental defectives. This is necessary to provide accurate information as to the extent and nature of the need. Massachusetts, South Dakota, Minne-

[1] Henry A. Tagdell and Bernardine Truden, "Traveling Psychiatric School Clinics: Twenty Years of Statewide Operation in Massachusetts," *Amer. J. Ment. Deficiency*, 47 (October, 1942), 220.

sota, New Jersey, New York, Connecticut, and Rhode Island are states having such a capital registry and continuing state census.[1]

Special classes Having determined the number of children needing such care, provisions should be made for education and training with a flexible, individualized course of study adapted to the needs, capacities, limitations, and interests of the individual. Although the conventional "three R's" are an integral part of the training, such education should emphasize good work habits and desirable social responses as well as health and useful forms of manual and industrial skills. In the large communities, special classes with a maximum enrollment of eighteen to twenty, in charge of well-trained teachers, are a partial answer to the problem. Or there may be classes which the mentally retarded attend for special training and drill, while taking the remainder of their work in regular classes. In other cases provision of "slow sections" in regular grades using a modified curriculum is a practical solution when there are only a few children so handicapped.

In thickly populated areas, special schools or centers may be established with highly trained personnel, special equipment, and a curriculum designed to help the pupil to adjust himself satisfactorily in the community and to prepare him for some unskilled vocation. Special vocational schools have been established in many communities. Care must be exercised in planning the activities of such centers, however, to avoid giving the pupils a feeling of isolation and exclusion. The environment must not be controlled to such an extent that the pupils do not experience the type of social situations which they must meet in the community.

Rural areas are faced with a very real problem in providing special education for the mentally handicapped. The number of such pupils is few and represents a wide age range as well as differing problems. In addition, school terms are shorter, distances between schools are greater, transportation is difficult, a large percentage of teachers are inexperienced, school staff turns over rapidly, and intelligent supervision and experience in utilizing special education facilities are usually lacking.

To meet these problems, adaptations must be made of several types of plans, according to the community to be served. Regular teachers may be given special training for individualized instruction of handicapped children in country schools and, where feasible, special

[1] Letter from Elise H. Martens, Senior Specialist in the Office of Education, Federal Security Agency, Washington, D. C., to the Illinois Commission for Handicapped Children, June 15, 1943.

classes may be formed for counties or districts, with transportation provided for the children attending. The necessary supervision of this work can be provided by traveling teachers, traveling clinics, and by appointment of county supervisors, as is the practice in Pennsylvania. A further possibility is provision of boarding care at State expense for non-resident pupils at larger centers.

By 1942 schools and classes for educable mentally handicapped children had been instituted in forty-two states.[1] Twenty-five states, in addition to Hawaii and the District of Columbia, now have programs of special education operating on a state-wide basis. All but five of these have one or more full-time supervisors.[2]

Service to rural areas was extended in 1942 by the appointment of county supervisors of special education in Pennsylvania, the first state in the Union to advance the program this far. These county supervisors are required to have state certificates as elementary or secondary school teachers, or as public school psychologists. Counties having more than 550 teachers have full-time supervisors, while those with fewer are served jointly with others. Activities of the supervisors are confined to special education and do not encroach upon the administration or supervision of the schools.

Another interesting phase of the Pennsylvania program is provision for transportation. In 1919, all Pennsylvania schools with an average daily attendance of ten or fewer pupils were closed,[3] and transportation to other schools provided, financed jointly with the local communities on an ability-scale of reimbursement. For the 1939-41 biennium, Pennsylvania appropriated $3,500,000 for transportation alone.[4] This is of great help in providing for students needing special education.

A major concern throughout in establishing any such program should be its interpretation to the community, instruction of parents as to the needs and problems of defective children, and interpretation of the special-class program to the regular teachers and pupils. Such interpretation would be conducive to the more effective carrying out

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[1] Martens and Foster, *op. cit.*, p. 7.

[2] Letter from Elise H. Martens, Senior Specialist in the Office of Education, Federal Security Agency, Washington, D. C., to the Illinois Commission for Handicapped Children, January 25, 1946.

[3] *Transportation of Public School Pupils in Pennsylvania*, Bull. 100, Department of Public Instruction (Harrisburg: Commonwealth of Pennsylvania, 1941), p. 1. Illinois has almost one-tenth of all the school districts in the United States, having over 12,000. In 1938 there were 400 schools with fewer than six enrolled pupils, 2,000 enrolling between six and ten pupils, and 5,002 with fewer than fifteen. (*See* Laura Hughes Lunde, "The Small Schools of Illinois," Department of Government and Education, Illinois League of Women Voters, Chicago, 1938, p. 1).

[4] *Transportation of Public School Pupils in Pennsylvania*, p. 2.

of the aims of special classes and would prevent the placing in them of children other than those for whom they are organized.

Teacher training The need for highly trained personnel in conducting special education procedures cannot be over-emphasized, since a major factor in success or failure of the program is competence of personnel. A teacher conducting classes for the mentally deficient should possess a state elementary or secondary school certificate; must be well qualified by reason of health, personality, adaptability, and interest in the welfare of the children to be served; and should have successfully completed a special curriculum in teaching and handling mentally deficient children. This type of curriculum is well illustrated by the special certification requirements adopted by the Pennsylvania State Council of Education for teachers of the mentally retarded. These include training in the psychology and education of exceptional children, diagnostic and remedial teaching, mental or educational hygiene, special class arts and crafts, class methods, corrective physical education, educational and vocational guidance, and in addition, teaching experience or successful experience in social service, public health work, or psychiatric clinic service.[1]

Various plans are being tested to provide in-service training for teachers. In 1942, the Superintendent of the Austin State School in Texas and the authorities of the University of Texas collaborated in making needed training available by offering summer courses in the education of the mentally deficient. An unusual experiment was conducted by the W. K. Kellogg Foundation in three counties in southwestern Michigan in the summer of 1935. Twenty-two teachers from the grade schools in these counties were given scholarships for an eight-week intensive course in speech correction at the Northwestern University School of Speech in Evanston. They returned to provide instruction in speech correction in county-wide service for rural schools in addition to carrying their regular work.[2] Such a plan could be extended advantageously to offer special services to mentally handicapped children where the school systems are too small to justify organization of special classes.

Institutional training Adequate institutional facilities should be provided for the mentally deficient who are so severely handicapped that they need full-time care, for those whose educational needs cannot be met by the community, or those for whom placement

[1] Lester K. Ade, *Meeting the Needs of the Mentally Retarded,* Bull. No. 420, Department of Public Instruction (Harrisburg: Commonwealth of Pennsylvania, 1939), p. 35.

[2] Henry J. Otto, "Utilizing Teachers' Special Talents in Small Schools," *Educ. Adm. and Supervision,* (January, 1937), pp. 41-42.

is desirable because of complicating personality or behavior problems or unfavorable home environment. The educational programs of such institutions should be made an integral part of the educational system of the state and should be differentiated from the custodial programs. As Elise Martens has observed:

> **When a child has been committed by order of the court to a State institution for the "feeble-minded" it is popularly supposed that his intellectual condition is hopeless. In the eyes of the community he is ostracized—relegated to institutional life for the rest of his days—unsuited to live among normal people. The door of community interest is closed upon him and he becomes a "forgotten man."[1]**

Safeguards against the assumption by state schools of a purely custodial aspect would include: (1) making the schools an integral part of the educational system of the state by placing the educational phases of their programs under the assistant superintendent in charge of the education of exceptional children, whose responsibility it is to plan and supervise that program under the direction of the State Superintendent of Public Instruction; (2) establishment of high personnel standards to insure staffing the institutions with highly trained and competent teachers; and (3) segregation of low-grade mental defectives from the educable mental defectives, with expanded facilities to include the colony system, and with a program of education, recreation, and vocational training designed to return the pupil to the community where he may live and work with a minimum of supervision or no supervision.

To fulfill its twofold purpose of custody for protection of the individual and society and for rehabilitation of the educable defective, therefore, the state institutional program should consist of the following:

1) Institutions for low-grade defectives who are in need of permanent custodial care, such as idiots and imbeciles.

2) Special facilities for mentally defective delinquents.

3) Cottage and colony systems supplementing the residential school program for educable mental defectives who can be trained to return to the community as self-supporting individuals, even though they may require some supervision. Such schools as the Syracuse State School in New York and the Wayne County Training School in Michigan, established on the cottage system, have proved quite successful. Social and medical studies, intelligence and educational tests, and vocational training are an integral part

[1] Elise H. Martens, *Residential Schools for Handicapped Children*, Bull. 1939, No. 19, U. S. Office of Education (Washington: Gov't Printing Office, 1939), p. 83.

of the program. Such schools offer training for boys in farm and factory work, mechanics, and various types of unskilled labor; and for girls in personal and domestic service, laundry and restaurant work, and certain types of factory work. Certificates of completion are granted by the county school authorities to pupils of the Syracuse State School who have made satisfactory progress.

It is especially desirable that a colony system be established to care for high-grade mentally deficient children for whom outside supervision is inadequate but institutional care too confining and regimented. The colony may be a mobile or permanent unit set up away from the parent institution, providing practical vocational experiences.

Twenty-seven years ago Rome State School in New York began the colony system as an experimental farm unit and now has twenty-six colonies for men and boys (with an average population of nineteen per colony) and twenty-two for girls (with an average population of twenty-four). The certified capacity of Rome State School is 2,500 but the actual inventory is 3,880, through use of colonies.[1]

For two years, a highly successful reforestation experiment was conducted by mobile colonies under the direction of the New York State Conservation Commission. Approximately 400,000 trees were planted at a cost to the state of only $400. One colony of fifty-eight boys boasted a net maintenance cost of $1.46 per boy weekly, or approximately $80 a year in 1940, in contrast with the minimum annual institutional cost of $363.[2]

According to reports, the domestic colonies for women are the "backbone" of the system of female colonies. For example, the per capita earnings of twenty-nine girls in the Syracuse colony in 1940 exceeded by $143.34 the cost of maintenance. Maintenance included spending money as well as food and clothing. In another instance, thirty girls in two homes operated as a unit in Rome had a deficit of only $498.79, a weekly per capita cost to the state of sixty-nine cents.[3]

The colony system relieves overcrowded conditions in institutions, provides practical experience in a working situation, stimulates the more promising children, and permits economy of organization and maintenance. It also provides a transitional state of experience between the institution and community life, and a good background for later family care or boarding-out care. One of the chief obstacles to successful operation of industrial colonies is opposition of labor

[1] Ward Winthrop Millias, "Thirty Years of Colonies," *Amer. J. Ment. Deficiency*, 45 (January, 1942), 415.
[2] *Ibid.*, p. 419.
[3] *Ibid.*, pp. 420-21.

groups and outside industry, a problem which would have to be met by compromise and understanding.

Family care Less than one-tenth of the feeble-minded are now confined in state schools, even in states with excellent institutional facilities such as Ohio, New York, and Massachusetts. Few states make extensive use of supervision for those who are not institutionalized. Most of those who are out in the community comprise the high-grade intellectually subnormal, who are making a more or less satisfactory adjustment to community life, but whose assets have remained unrealized for lack of any comprehensive effort to develop their capabilities. It is neither possible nor desirable to expand institutional facilities to care for them. Thus, if they are to be properly guided and helped, a plan for extra-institutional supervision must be established, not only to care for those who have not had and do not need institutional care, but also those who have benefited from years of training in institutions.

Family care for mental defectives is not new. It has been successfully used in Belgium, Germany, and Scotland, and has provided a widely used resource in New York and Massachusetts, where 11.0 per cent of mental retardates are on "parole."[1] New York has 900 in foster care, Massachusetts over 300, and Ontario, Canada, about 500.[2]

Briefly, such a family care plan for Illinois would include: (1) placement of high-grade defectives in boarding homes where they may be supervised by a foster mother; (2) multiple placement in training homes where they may be trained and supervised in specified vocations preparatory to wage placement; and (3) placement in wage-homes where they may earn their maintenance and a small sum in addition.

Massachusetts began to experiment in 1915 with a parole program, through which boys and girls considered fitted for community life are placed in positions for which they receive pay, and are supervised by field workers from the parent institution. By 1940, the three state schools of Fernald, Wrentham, and Belchertown boasted 223 girls and 106 boys on parole, who had earned $45,747.84, or an average weekly wage of $2.60 plus maintenance during the period of their parole, thus proving their claim to at least a degree of economic independence.

With the creation of a Division of Mental Deficiency within the Department of Mental Health in 1924, a highly specialized family-

[1] Horatio M. Pollock, "Mental Patients in the Community," *Amer. J. Ment. Deficiency*, 46 (July, 1942), 245.
[2] Pollock, "The Future of Family Care of Mental Patients," *Proceedings*, Amer. Ass'n of Ment. Deficiency, 63 (June, 1938), 235.

care program was developed in Massachusetts. It provides: (1) supervisory home training and teaching service for preschool defectives and those who have been refused admission to the public schools or are on the waiting list of the state schools; (2) social supervision of special-class pupils in attendance at or released from special classes, with regard to personality problems, recreational plans, and vocational guidance; (3) placements in training homes providing boarding-care and training for potential wage-earners, under the supervision of an understanding foster mother who gives them special training in child care, cooking, and general housework; (4) placement of wage-earners in wage homes for room, board, and wages; (5) boarding-out or family care for potential wage-earners as well as for low-grade mental defectives who are not suitable for wage placements but who have benefited from years of training in institutions, and (6) general supervision and consultation for cases usually cared for in their own homes but needing guidance and assistance in social adjustment.

Boarding-care for mental defectives costs less than institutional care, according to Massachusetts experience. Annual expense for boarding-care in 1940 was $350 per patient, against a maintenance cost of $363 in the institution.[1] Kuhlmann believes that boarding-home and wage placements tend automatically to adjust themselves to fluctuating economic conditions, since, during depressions there would be a demand for them because of the added income to the home, and, during good times, mental defectives are more easily employable because of the demand for labor.[2]

Vocational guidance and placement Even the most elaborate training program will be futile without adequate provisions for vocational guidance, placement, and adjustment. This should be available both for the institutionally trained and the special-class pupil who has reached the limit of his capability for training and is socially mature to the extent that he may be expected to achieve adequate adjustment in the community. Community surveys of opportunities for placement of retarded children should be made, and a program of community education and organization should be conducted to secure public support, co-operation of employers, and the interest of labor groups.

Adaptation of the training program to permit the child to spend one-half of his time during the last year in school in industry and

[1] Neil A. Dayton and Marion A. Nugent, "Community Supervision of Mental Defectives in Massachusetts," *New Eng. J. Med.*, 225 (December, 1941), p. 944.
[2] F. Kuhlmann, "One Hundred Years of Special Care and Training," *Amer. J. Ment. Deficiency*, 45 (July, 1940), 22.

the other half in school, has advantages in that studying the child on the job is probably the most effective way to discover his capabilities and occupational shortcomings, and it affords an opportunity for the employer to evaluate the child's ability to carry out the job.[1] The training program should be based upon an analysis of job opportunities available, for if graduates are not enabled to find useful occupations in the community, the program is futile, however wide may be the range of manual and vocational activities offered during the training period. This would involve a more adequate program at the local level of vocational guidance and placement for all children.

Organization and administration Implementation of a state program should be through a centralized, well organized and administered state division of special education with supervisory service for local districts. The functions of this central organization should include: (1) establishment of standards of special-class organization and teacher training; (2) setting up methods and procedures; (3) co-ordinating clinical and educational services in city day schools and institutions; (4) providing facilities for vocational guidance, education, and adjustment; and (5) maintaining a central record bureau. Some of these functions are now being carried out in Illinois by the assistant superintendent in charge of education of exceptional children and his staff of specialists in the Office of the Superintendent of Public Instruction. Although this is not an administrative division, it does in actual fact function as one.

Although leadership should come from the State, responsibility for the local program should be in the hands of local school officers. Such local participation is essential since no program for the mentally retarded is adequate without the support and collaboration of all agencies concerned—school, home, institution, social welfare organization, and the general public. As Elise Martens has stated:

> No person or group of persons, however skilled, can superimpose a curriculum upon classroom teachers working in a thousand different situations. Specialists can only point out the way in which a curriculum can be developed locally. They must leave to the State and to the community the task of applying the principles evolved to the situation at hand. Community conditions must be recognized, geographic factors considered, and social interests observed. All of this can be done only by persons who are familiar with State and community situations.[2]

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[1] J. E. Wallace Wallin, "The Classroom Teacher and Child Guidance Particularly with Respect to Handicapped Children," *J. of Ed. Res.*, (Jan. 1943), 321-334.

[2] Martens, *A Guide to Curriculum Adjustment . . .*, p. 3.

Costs and financing For a centrally planned, organized, and administered state-wide program, the financing of special education for the mentally handicapped child presents a problem of joint state and community financing. Assumption by the State of responsibility for excess costs for small towns and rural areas is essential.

The General Assembly of Illinois recognized this fact when it appropriated funds for the 1945-47 biennium to reimburse local school districts for the excess costs of the education of mentally handicapped children up to $100 per year per pupil. Wisconsin and Minnesota appropriate like amounts; New Jersey, $500 per teacher; Missouri, $300 to $750 per teacher, depending upon the degree of handicap of the pupils;[1] while the per capita reimbursement from the State of California to the Los Angeles City School District in 1940-41 was $184 for elementary school pupils and $225 for secondary school pupils.[2]

Prevention Preventive methods in the field of mental deficiency resolve largely into matters of public health and education. There are many positive steps which can be taken in promotion of maternal and child health which would be effective in prevention of certain types of mental deficiency. Among these are adequate prenatal and post-natal care to prevent mental deficiency caused by endocrine disturbances, malnutrition, injuries, and syphilis; public health methods to prevent incidence and spread of infectious diseases which damage the brain (encephalitis, meningitis, measles, syphilis, etc.); and better obstetrical care, to reduce the number of birth injuries. Social services in marriage consultation offer a further resource. Two negative control measures of doubtful value have been suggested: (1) segregation of all mentally handicapped in institutions, which is neither desirable nor possible, and (2) sterilization, the efficacy and feasibility of which is widely questioned.

Facilities for the Mentally Retarded in Illinois

Diagnostic services Diagnostic services for mentally handicapped children in Illinois are of two types: (1) those providing diagnostic study of the individual child (social, psychiatric, psychological, and medical); and (2) those providing diagnostic, consultative, and advisory services only. Both types of services are provided

[1] Martens, *State Supervisory Programs for the Education of Exceptional Children*, Bull. 1940, No. 6, Monograph No. 10, U. S. Office of Education, Federal Security Agency (Washington: Gov't Printing Office, 1941), p. 8.

[2] *Schools and Classes for Exceptional Children—the Child with a Problem*, Los Angeles City School District, School Pub. No. 373 (Los Angeles: Los Angeles City Schools, 1941), pp. 6-7.

on a state-wide basis by the Institute for Juvenile Research, a Division of the State Department of Public Welfare, with headquarters in Chicago. At its headquarters clinic and through community clinics held periodically throughout the year in many of the larger communities of the state, the Institute serves each year approximately 2000 children up to the age of eighteen. Diagnostic and consultative services are also offered by the Institute to county, juvenile, circuit, and probate courts and to state institutions for children and youth under the Department of Public Welfare. The Institute also participates in permanent child guidance clinics maintained by certain local communities.

The Bureau of Child Study of the Chicago Board of Education, which provides psychological services to all school children from preschool through junior college, whether enrolled in public school or not, maintains clinics for diagnostic reading, speech, behavior, psychiatric study, audiometer testing, vocational guidance, and examination for admissions to special schools and classes. Every 1B entrant into the schools is given a Kuhlmann-Anderson Group Intelligence Test and Metropolitan Reading Test. Those with mental ages of 6.0 or less are selected for particular study and special work. In 1940-41, a total of 88,048 group tests were given and 6,438 individual psychiatric studies made.[1] The Bureau clinic is operated two days a week for examination and treatment of children referred from the regular elementary and high schools of the city. Other children are referred by parents, social agencies, clinics, private and parochial schools, and interested private persons.

Public services outside of Chicago are comprised of services by the Institute for Juvenile Research, Division of Child Welfare, and the schools, as well as certain state teachers colleges and the state schools for the feeble-minded.

Two excellent school programs in Illinois are the LaSalle-Peru Township Bureau of Educational Counsel at LaSalle and the Department of Educational Counsel of the Winnetka Public Schools. The LaSalle-Peru Township High School was the first school organization in the state to establish a mental hygiene program for students in attendance. Organized today as the Bureau of Educational Counsel, it has a full-time psychiatric social worker and is served at intervals by a psychologist and a psychiatrist from the Institute for Juvenile Research. Intelligence tests and school achievement tests are given to all high school and junior college students

[1] *Annual Report of the Superintendent of Schools, 1940-41* (Chicago: Chicago Board of Education, 1941), pp. 398-99.

routinely. In Winnetka, full-time psychological and psychiatric service is given to children in the Winnetka Public Schools. Occasionally, on special request, psychological examinations are made of children outside of the Winnetka school system.

Private clinics have been developed in connection with schools, universities and hospitals such as the Orthogenic School of the University of Chicago; the Loyola University School of Medicine; Northwestern University; and various Chicago hospitals.

Outside of Chicago, child guidance services are offered by private clinics operated in several of the larger cities of the state.

Institutional facilities There are two state schools for the mentally defective in Illinois, Dixon State Hospital and Lincoln State School and Colony, each of which has an approximate capacity of 4,500 beds. There are at present about 450 educable defectives in the latter school, and 300 in the former.[1] Occupational therapy, academic school, recreation, and industrial training are included in the program for the educable handicapped in these institutions.

Defective delinquents are committed to Lincoln State School and Colony, but may also be sent to the state correctional schools.

Although some smaller private homes with limited intake and restricted programs are in operation, there are four private institutions of sizeable capacity in Illinois, caring for an aggregate of approximately 200 children.

Special class facilities The actual number of mentally retarded children receiving special instruction in Illinois schools is estimated at less than 10 per cent of the minimum needing such care. The United States Office of Education reported that in 1939-40, Illinois had 4,252 mentally deficient children enrolled in special schools and classes in city school systems and 896 enrolled in classes in public and private residential schools, a grand total of 5,148 children receiving the benefits of special training.[2] Illinois stood ninth among all states in this regard, being surpassed by New York, Pennsylvania, Massachusetts, Ohio, Michigan, Maryland, New Jersey, and California.[3] In 1942, the Illinois Commission for Handicapped Children conducted a survey of cities with a population of 10,000 and over, the results of which indicated several different types of special education being offered in various downstate communities.[4]

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[1] Statement to Illinois Commission for Handicapped Children by W. G. Murray, M.D., January 29, 1946.

[2] Martens, *Statistics of Special Schools and Classes*, pp. 12, 115.

[3] *Ibid.*, pp. 12-13.

[4] A list of special classes and schools in Illinois may be found in the Commission's report, *Facilities for the Education and Institutional Care of Mentally Handicapped Children in Illinois* (Chicago: Illinois Commission for Handicapped Children, 1942), pp. 9-17. Additional classes are reported in the statistical summary by Martens and Foster, *Statistics of Special Schools and Classes for Exceptional Children, op. cit.*

The Superintendent of Public Instruction, as required by law, has set up standards for special class procedures relating to the size of classes, location, admission, equipment, and curriculum, as well as standards for teacher qualification and approval of psychological examiners who under the law determine the eligibility of pupils for special classes. Uniform systems of record-keeping are required.[1]

Special schools There are local special schools for mentally retarded older pupils in Danville (Promotional School), East St. Louis (Roosevelt School), and Chicago (Pre-Vocational and Vocational Centers). These schools provide full-time segregated instruction and training adapted to the limitations and needs of the pupils, with individualized programs of academic education in addition to manual training. In the Lower Vocational Centers of Chicago, pupils may work toward an eighth grade certificate or direct all their efforts toward vocational training. Such centers are maintained for both boys and girls. In 1940-41 there were 101 Lower Vocational classes in 31 elementary schools in Chicago, 66 for boys, and 35 for girls, making possible considerable departmentalization.[2] The six Vocational Centers are maintained for those unable to profit from courses and materials in the regular schools. One is for girls only. These centers offer a two-year course, with Smith-Hughes certificates awarded upon graduation.

In addition, Chicago maintains two special schools for children who present special behavior problems which cannot be handled in the regular schools. At these two, Montefiore and Mosely Special Schools, a psychiatrist and two psychologists from the Bureau of Child Study give diagnostic and treatment services. Montefiore has a full-time psychologist, special teachers for subnormals who are also behavior problems and truants, and a staff of social workers.

Auxiliary services Finally, as auxiliary services, there are the public and private social agencies which are depended upon to perform limited services in school adjustment of the mentally retarded. The education of these handicapped children should not be the concern of the schools alone, but should involve as many community resources as possible. In Chicago there are several family welfare agencies which may be called upon for services needed. Outside of Chicago most of the larger cities have similar resources. Public welfare services are provided by the Division of Child Welfare, the Aid to Dependent Children and the Child Welfare Advisory

[1] The Illinois Plan for Special Education of Exceptional Children: *The Educable Mentally Handicapped.* Circular Series B, No. 12, issued by Vernon L. Nickell, Superintendent of Public Instruction.

[2] *Annual Report of the Superintendent of Schools,* p. 479.

Service and Maternal and Child Health programs operated under the Social Security Act.

Occupational adjustment services are offered to a limited degree by the Jewish Vocational Bureau of Chicago and the work relief program of the United Charities and the Chicago Welfare Administration. The Division of Vocational Rehabilitation has now extended its facilities for guidance and placement to the mentally handicapped under the provisions of the 1943 Federal Rehabilitation Act.[1]

Of special importance is the program of the Illinois Commission for Handicapped Children, a State commission created to stimulate private efforts, co-ordinate the services of State departments, and promote medical care, education, and vocational training and placement for physically and mentally handicapped children. The efforts of the Commission as a fact-finding and co-ordinating agency have found fruition in recommendations to the General Assembly regarding important action to be considered with respect to administrative organization, the drafting of bills providing for the greater welfare of the handicapped child, and stimulating of public interest in the problems of these children.

Unmet Needs in Illinois

Although the facilities listed above may seem extensive they are far from adequate and are most inequitably distributed. In fact, to remedy these inadequacies would of itself require development of a complete state program. The needs of such a program are: administrative, institutional, educational, vocational, and research.

The administration of aspects of the program for educable mentally handicapped children is closely related to the whole problem of special education—at present the most neglected phase of public education in Illinois. There is urgent need for establishing a broad, well-planned, well-financed program of special education under the direction of a skilled and specially trained administrator. Such a program should be developed with careful attention being given to the needs of the mentally retarded, numerically the largest of any of the handicapped groups in the state. These individuals are widely scattered throughout the population. If their diverse problems are to be met adequately, an administrative setup must be developed which can effectively co-ordinate and utilize all of the child welfare services of public and private agencies and institutions. Staff and

[1] Public Law 113, (78th Congress) effective July 6, 1943.

social services of the institutions should be expanded to provide adequate educational and vocational training, relieve over-crowding, and reduce the long waiting lists. The educational planning in the state schools should be co-ordinated closely with that of special classes in the community, and a clearer differentiation drawn between those eligible for special-class placement and those requiring institutionalization. Adequate provision for defective delinquents is urgently needed. Commitment to correctional schools neither meets the needs of such delinquents nor helps to make them socially adjusted or socially useful; confinement in state schools for the mentally retarded presents equally difficult problems because of the delinquent tendencies of this group.

Methods of record keeping in local and state schools need to be standardized to facilitate program planning for students who are transferred from one school to another.

Since therapy among the mentally retarded is largely educational therapy, there is great need for training physicians, social workers, and teachers with special aptitudes for working with these children. Throughout, the highest of personnel standards are necessary, since the success of the program depends upon the care and intelligence with which it is carried out. It is not necessary that each teacher-training institution have a full curriculum for training teachers of special classes, but there should be specified centers where this training is available, and each school should offer to teachers in training courses designed to develop skills in recognizing and handling the problems of exception children, and in use of resources available. The establishment of child guidance bureaus in each of the teacher-training institutions would do much to further the general knowledge of resources and techniques which every teacher should have.

There is also need for expansion of child-guidance services, including psychiatric social service and psychological service. Among psychologists there are wide discrepancies in competence of personnel and standards of service, indicating the need for more uniformity in standards, procedures, methods, and interpretive techniques.

One of the most urgent needs in Illinois is the reorganization of school districts, consolidating small schools to permit greater economy of operation and higher personnel standards, and to facilitate the financing of special classes in the larger districts.

The county school survey law, passed by the 64th General Assembly, provides for study and action on this problem by authorizing

the creation of county survey committees and gives them the power and makes it their duty to study the school districts of the county and their organization for the purpose of recommending the reorganization of districts where such reorganization will afford better educational opportunities, better administration, and more equitable distribution of public school revenues.[1]

Extension of the program of the Division of Vocational Rehabilitation at the state level and development of community resources to provide vocational guidance and adjustment services to the mentally handicapped, including inquiries into job opportunities and a campaign of enlightenment among employers as to assets and potentialities of this group as employees are of utmost importance.

There is an urgent need for intelligent interpretation of the problem to the public. Local pressure groups, legislators, teachers, and public school officials, as well as the public at large, must be given an understanding of the needs of this group of handicapped, so that backing and support for an adequate state-wide program may be secured.

And, finally, there is a never-ending need for research into the nature and extent of the problem of mental deficiency and means of preventing it. At the present time, Illinois is ill-equipped for adequate social planning for the mentally handicapped, hampered as it is by so great a lack of information. Up to this time there has been no systematic effort to discover the mentally deficient, only the obvious or behavior problem cases generally being the ones identified. There is need, therefore, for a continuing annual census of the handicapped, with a central registry for cases. The information this would provide would greatly facilitate intelligent state-wide planning. The research program should also include study of legislative practices, programs, and experiences of other states; institutional methods; methods and standards of teacher training and curriculum organization; child guidance procedures; social adjustment of the mentally retarded; co-ordination of state services; and occupational adjustment. Without the flexibility of a continuous adaptation to research findings, the work would become static and progressively less effective and valuable in meeting the needs of those for whom it is designed.

[1] House Bill 406, approved June 20, 1945.

Recommendations

In view of the many needs of educable mentally handicapped children in Illinois which are not now being met, and the loss to the individual and the State resulting from failure to develop to the fullest extent the assets and capabilities of this group of handicapped, certain suggestions may be offered with respect to improvement of services to these children.

Administrative and educational All educational services to the mentally retarded, whether in public schools or institutions, should be co-ordinated under one division or bureau directed by a specially trained, full-time supervisor, responsible to the Superintendent of Public Instruction. This responsibility is at present divided between the Department of Public Welfare and the Superintendent of Public Instruction. A centralized administration would achieve co-ordination of efforts of the various state and community agencies, and would be the logical point for establishment of a central registry of all mental defectives.

The 64th General Assembly appropriated the sum of $598,000 for the excess cost of education of mentally handicapped children in local school districts during the 1945-47 biennium. Such provision for State participation is a tremendous step forward, and continued appropriations are a necessary part of future development of a complete state-wide program.

Rural areas should be provided for through supervisory services by traveling teachers, transportation of pupils to special-class centers, and the use of boarding-home care in larger cities. Throughout the state, auxiliary services of visiting teachers and school counsellors should be expanded to meet the need for assisting parents in handling adjustment problems, to aid in the social and occupational adjustment of mentally handicapped children, and to interpret the problem to the community. At the present time, attendance officers enforcing the compulsory education law are in most places the only school representatives coming in contact with the child outside his school environment.

These administrative provisions and changes will require the consolidation of the many small school districts in Illinois for purposes of improvement of educational services and better economy. Educational opportunities throughout the state should be equalized by increasing the state distributive funds so that they cover at least one-fourth of school costs. Such consolidation and additional revenue would give impetus to the establishment of special classes to serve

the larger districts, whereas limited enrollment in the present unconsolidated districts makes such classes impossible.

Adaptations of the secondary school curricula should be made for the mentally handicapped adolescent, through provision for individual instruction in regular classes or special classes and schools, or by a home training and teaching program[1] in rural areas under the supervision of traveling teachers. This would fill one of the greatest needs in the Illinois educational program.

State-wide standards for teacher training and certification should be established and maintained, both with respect to public schools and public and private institutions for the mentally retarded, in order that teachers be trained to recognize problems and intelligently guide the training of their charges. Such teachers should receive higher salaries than the regular teachers, since they require training in addition to that which is necessary for qualification for regular certificates. Organized courses should be instituted for training of teachers in service as well as for new teachers. Such teachers should be selected on the basis of their natural aptitudes and their interest in the problem of the educable mentally handicapped child.

Institutional The inadequacy of present institutional facilities can be remedied by making various changes and additions.[2] In the first place, the development of a well-rounded educational and vocational program and the minimizing of the custodial aspects of institutionalization at Lincoln and Dixon require an increase of staff—psychologists, social workers, teachers, occupational therapists, physicians, and attendants. In this connection, it must be stressed that adequate salaries are imperative to attract competent persons and to prevent the disorganizing effects of frequent staff turnover.

In the second place, the facilities of Lincoln and Dixon should be extended and supplemented to provide segregation of mentally defective delinquents and cottage and colony systems for educable mental defectives who can be trained to return to the community or who need more than outside supervision, but for whom institutional care is not necessary.

The establishment of farm and industrial colonies for mental defectives is highly recommended, both to relieve pressure on the state

[1] See "A Home Training and Teaching Program for Mentally Defective Children to Be Taught by Parents in the Home," by Marion A. Nugent in *American Journal of Mentally Deficiency*, Vol. XLV, No. 1, July 1940, for a description of the operation of such a program in Massachusetts.

[2] Detailed recommendations for improving the institutional services in Illinois may be found in the report of the "Sommer Committee on the Release and Training Program at Lincoln State School and Colony and Dixon State Hospital," (Chicago: Neuropsychiatric Institute, 1942), and the unpublished report of Dr. Samuel W. Hamilton, "A Survey of the Lincoln State School and Colony," made under the auspices of the United States Public Health Service, 1941.

schools and to provide specialized training for those potential wage-earners who are adaptable to community life.

A state-financed plan of boarding-out or family care for mentally deficient children under the supervision of well-trained workers would be of great value, not only to reduce overcrowding at the state schools, but also to provide highly effectual treatment service at nominal cost. Although the Illinois law provides that mental defectives may be committed to the Department of Public Welfare as wards of the State, this provision has been operative only when such persons are committed to the state schools. This procedure should be utilized to full advantage, encompassing all mentally deficient children who need the care and supervision of the State, in order that services be provided in the home and community for thousands of children now neglected, and that there be a continuity of service. In smaller communities, the extension of school nurse facilities, with nurses trained in mental hygiene and psychology, would provide an excellent resource. Such care given now would avoid the expense to the taxpayers of years of custodial care in correctional institutions or support as dependents in later life for large numbers of these children.

Little provision is made for social service study and investigation of cases committed by the courts to Lincoln and Dixon or to private institutions or released to private guardianship. Such studies should be made in all cases to facilitate suitable placement plans and follow-up care. A well-planned program of habit training and vocational and industrial training is needed, with a view toward returning as many patients as possible to the community. The social welfare considerations involved entail considerable expansion of the social work staff of the institutions. In this connection, it is recommended that parole and discharge, at present a function of the courts, be placed under the control of the managing officers and that acceptance of voluntary admissions be made possible without court procedure. In many cases much of the burden on state schools could be relieved through establishment of a small receiving hospital where mentally deficient children could be received for short-time care and observation and direct boarding-home placement without institutionalization. Such a receiving hospital could also serve as a placement agency for the state schools and would add to the limited diagnostic services existing in Illinois.

Fullest utilization should be made of child welfare services offered under the Federal Social Security program. Under the Maternal and Child Health program, identification of defectives is facilitated, and counseling service provided for parents in the training

and treatment of retarded children. Of particular significance is the Federally subsidized Child Welfare Advisory Service, which has as its aim the development of resources for dealing with maladjusted children in rural areas and promoting community organization.

Identification and diagnosis Fundamental to the establishment of such a program in Illinois is a state-wide system of case-finding and registration of all mental defectives. A selective central registry could be started by collecting data now in the hands of schools, courts, correctional institutions, and public and private institutions and agencies. A continuing official school census should be authorized providing for examination of all children retarded three years or more in school, with permissive examination of those less retarded, and for examination of all entering school children. In addition, all children in correctional institutions should be examined to determine proper placement. Such examinations require the services of school psychologists, extension of the work of the Institute for Juvenile Research, and full-time traveling units from each of the state teachers colleges and the state schools.

Since no tests should be given except by experienced clinical psychologists, the competence and standards of service of psychological personnel are highly important.

Vocational Extensive and coordinated plans for vocational education, guidance, training, and placement, with follow-up care and supervision, are urgent. This could be accomplished through the services of the Division for Vocational Rehabilitation and by extending those of the State Employment Service to handle the occupational adjustment needs of special class pupils and institutionally trained defectives, and provide a liaison between employable retardates and employers. Perhaps supervision of the child, upon his reaching the age of employability, should be transferred to the Division for Vocational Rehabilitation. A cataloging by local, state, and federal employment agencies of occupations open to the mentally handicapped, and maintenance of employment lists for them is essential. Strategically located sheltered workshops for training of mentally handicapped adolescents are necessary to provide for those who have passed the compulsory school age limit or who are unable to function efficiently within the standard school program. Where no such additional educational facilities are provided, it should be made possible for such children who reach the age of fourteen to find employment under supervision, through certification under the State Child Labor Law.

Public education Since progress will depend upon the degree to which the program gains public understanding, acceptance, and support, a fundamental aspect of the work consists of promoting community understanding of the problems of the educable mentally handicapped child, both among lay and professional persons. Public enlightenment can be promoted through publications, public meetings, exhibits, conferences, parent-teacher meetings, the radio, demonstrations, and pageants. If sufficient public demand is created through leadership of influential persons and organizations, legislators can move ahead with the knowledge that they are doing what the public *wants* them to do.

Research Basic in development and maintenance of a vigorous program is continuing and well-directed research and its practical application to the operation of the program. The following surveys should be made on a state-wide basis: (1) the number of mentally handicapped children and the nature of their retardation; (2) educational facilities available and needed; (3) the mental status of children in correctional institutions, to sift out those who should not be placed there; (4) occupational histories of children trained in special classes and institutions, to determine the degree to which the training they have received is adaptable to opportunities for employment in Illinois, whether they have been wisely placed, or whether other types of training are indicated; (5) employment opportunities in Illinois for the mentally retarded; (6) follow-up studies of social adjustment of the mentally retarded, with a view to making appropriate curricular changes where needed.

Although all objectives are not at once attainable, there is a definite goal toward which to work: a state-wide program based upon development of local resources and facilities, with participation by the State at all points in the program where financial support, supervision and co-ordinated planning are needed, and with a system of institutions for those children who cannot profit from education elsewhere.

Adequate educational provisions for the mentally handicapped child are a form of social insurance, since the price to be paid for dangerous neglect in ignoring the problem and failing to utilize the assets and potentialities of these children is far in excess of the cost of the program. Kuhlmann has said of the mentally handicapped child:

> In most other lines of human endeavor progress has been less dependent upon the judgment and will of the public. It could hardly have been otherwise. We are dealing directly with human

beings, and not with matters that may only indirectly affect their welfare. We are dealing with that part of human nature which ever since man became self-conscious has been looked upon as his most enviable possession—intelligence. . . . Unlike the physically crippled, it looks on mental deficiency as stigma and disgrace rather than as a misfortune.

Thus it has come to pass that we deny him the right to the kind of rearing and training that he needs, and which we could give; the right to fit into a useful place in the world, which we could supply; and the right to happiness, although we *demand* all these for the normal child and adult. And when we have done all this, we will speak more of the wrongs he does to society than of the wrongs society does to him. Truly, his greatest handicap is not the fact that he has failed to grow up mentally, but rather the neglect of an uninformed public that holds the key to his welfare but refuses to unlock the door.[1]

[1] Kuhlmann, *op. cit.*, pp. 19, 23-24.

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